



FOUNDATION STONE MEDICINE

Dr Sandy Musclow  
ND, MAC, MSc, PGeo.  
Bancroft & Madawaska Valley  
P: 613-334-9802 F: 613-380-8044  
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[foundationstonemedicine.com](http://foundationstonemedicine.com)

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## PEDIATRIC PATIENT INTAKE

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**Patient Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_ Parent 2 Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Parent Home Phone: \_\_\_\_\_ Parent Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Dr office where child's health records kept: \_\_\_\_\_

How did you hear about Foundation Stone Medicine? \_\_\_\_\_

Reason for visit: \_\_\_\_\_

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## MEDICATIONS

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	Now	Past
Aspirin		
Tylenol		
Decongestant		
Ibuprofen		
Antibiotics		
Anti-histamine		
Other		

Allergies to medicines or foods:

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## MEDICAL HISTORY

CHICKEN POX:		TONSILLITIS (#s):	
MEASLES:		EAR INFXNS (#s):	
MUMPS:		PNEUMONIA:	
RUBELLA:		Other (List):	
SCARLET FEVER:			

Has your child had any of the following tests, please include date, where performed, and the results:

Electroencephalogram	
Psychological Evaluation	
Hearing Tests	
Speech/Language	
Injuries	
Surgeries	
Hospitalizations	

## IMMUNIZATIONS

Measles:		Polio:		MMR:		Smallpox:		Diphtheria:	
Mumps:		DPT:		Tetanus:		Influenza:		Other:	

Were there any adverse reactions? Y N What were they? \_\_\_\_\_

## FAMILY HISTORY

Heart Disease:		Mental Illness:		Tuberculosis:		Birth Defects:		Hypertension:	
Arthritis:		Diabetes:		Asthma:		Cancer:		Allergies:	

## PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_  
Mother's age at child's birth: \_\_\_\_\_



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### Mother's health during pregnancy:

Bleeding:		Physical/Emotional Trauma:	
Nausea:		Cigarettes, Alcohol, Drug use:	
Illnesses:		Medications:	
Hypertension/Diabetes:		Thyroid problems:	

## BIRTH HISTORY

Term: FULL \_\_\_\_\_ PREMATURE \_\_\_\_\_ LATE \_\_\_\_\_ Weight at Birth \_\_\_\_\_  
Length of Labor: \_\_\_\_\_ Complications? \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

Birth defects:	Blue Baby:	Cerebral palsy:	Rashes:	Jaundice:
Birth injuries:	Fever:	Seizures:	Colic:	Other:

Child's sleep patterns in first year: \_\_\_\_\_

Food intolerances (if any): \_\_\_\_\_

Feeding: Breast-fed?: \_\_\_\_\_ How long?: \_\_\_\_\_ Formula?: \_\_\_\_\_ Milk/Soy \_\_\_\_\_

Age began solids: \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_ Talking: \_\_\_\_\_

## SYMPTOMS

Mark Y if current and P for past symptoms:

<input type="checkbox"/> Hives	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Nervous
<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep issues
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Vomiting spells	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Anemia	<input type="checkbox"/> Sensitive to light
<input type="checkbox"/> Acne	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Body/Breath odor
<input type="checkbox"/> High fevers	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Motion/Car sickness
<input type="checkbox"/> Chronic rash	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> No appetite
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Flat Feet	<input type="checkbox"/> Sore throats
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Headaches
<input type="checkbox"/> Burning of urine	<input type="checkbox"/> Cries Easily	<input type="checkbox"/> Frequent Colds



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- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Wheezing     | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Canker sores      |
| <input type="checkbox"/> Cough        | <input type="checkbox"/> Joint pains       | <input type="checkbox"/> Unusual fears     |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizzy spells      | <input type="checkbox"/> Excessive Fatigue |
| <input type="checkbox"/> Gas          | <input type="checkbox"/> Nightmares        | <input type="checkbox"/> Hair loss         |

## DIET

What foods were introduced before 6 months (please list approximate months as well): \_\_\_\_\_

6-12 months? \_\_\_\_\_

Did your child ever experience colic: \_\_\_\_\_ How severe? \_\_\_\_\_

Please list any allergies or food intolerances, and the reaction that occurs: \_\_\_\_\_

What foods does your child insist upon? \_\_\_\_\_

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc)? \_\_\_\_\_

Typical Breakfast: \_\_\_\_\_

Typical Lunch: \_\_\_\_\_

Typical Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

## ENVIRONMENT

Describe your child's sleep pattern: \_\_\_\_\_

How would you describe your child's temperament? \_\_\_\_\_

Is your child in school? \_\_\_\_\_ What grade? \_\_\_\_\_ Daycare? \_\_\_\_\_ Other? \_\_\_\_\_

How would you describe your child's behaviour and performance in school? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_



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Does your child exercise regularly? \_\_\_\_\_ How much, how often? \_\_\_\_\_

How much TV/screen time does your child get? \_\_\_\_\_ hrs/day or week

Does anyone in the child's home smoke, even just outside? Y N

Are there animals in the home? Y N What are they? \_\_\_\_\_

*Thank you for filling this out. I look forward to working with you and your child!*



## INFORMED CONSENT FOR TREATMENT

Naturopathic medicine (also known as Naturopathy) is a distinct branch of primary health care that focuses on treating the root cause of illness and disease by stimulating the healing power of the body. It blends modern scientific knowledge with traditional and natural forms of medicine, while minimizing the use of surgery and drugs. Treating both acute and chronic conditions, Naturopathic therapies are chosen based on the individual patient and their extensive case history while taking into account physiological, psychological, environmental, and lifestyle factors. A number of different modalities are used as treatment, which includes botanical medicine, clinical nutrition and supplementation, homeopathy, hydrotherapy, physical medicine, traditional Chinese medicine and acupuncture, and lifestyle counselling.

- Botanical medicine (herbalism) is a plant-based medicine that uses teas, tinctures, capsules, and other compounds to assist the body in recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.
- Clinical nutrition and supplementation are recommended to address deficiencies, treat disease processes, and promote health. The benefits include increased energy, increased digestive health, improved immune function and general well being.
- Homeopathy is a form of energetic medicine based on the Law of Similars - simply described as the use of tiny doses of naturally occurring substances to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and effects healing on an emotional as well a physical level.
- Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.
- Classical Chinese medicine is a system of care based on many centuries of knowledge that includes acupuncture, dietary recommendations, and botanical medicines. These various treatments are used to eliminate disease and restore balance in the body's functions through the manipulation of Qi (energy). Sometimes cupping is used over an acupuncture point to relieve symptoms.
- As Naturopathic medicine is a holistic approach to health, lifestyle is considered relevant to a Naturopath's approach to most health problems. Thus, the identification of lifestyle risk factors will allow for recommendations to be made that will help to optimize physical, mental, and emotional environment.

At your first appointment you can expect a thorough history taking and relevant physical examination. This may include urine testing, ordering of blood work or a breast or pelvic examination. Because some therapies must be used with caution when dealing with particular conditions (such as pregnancy and lactation, kidney disease, and heart disease), it is very important that you inform your Naturopathic doctor immediately of any disease that you are suffering from, as well as any forms of medication, drugs, or supplements you are taking. There exist slight health risks when receiving treatment by Naturopathic medicine. These risks include, but are not limited to, aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising, fainting, or injury from acupuncture; puncturing of an organ with acupuncture needles; accidental burning of the skin from the use of moxa; muscle strains or disc injuries as a result of spinal manipulations. These risks may vary depending on the modality used. I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by me, unless the law requires it. I understand that I may look at my medical records at any time, and can request a copy of this record by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I understand that the practitioner will answer any questions that I may have to the best of her ability. I understand that results cannot be guaranteed. I do not expect the Naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on



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the Naturopathic doctor to exercise her judgement during the course of the procedure which she feels at the time is in my best interest, based on the facts then known. Potential benefits may include symptom relief, improved function, or improved quality of life.

With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment for my present condition, recognizing that treatment recommendations may change over time and that consent may be revisited as needed. I understand that my naturopathic doctor will discuss and obtain my consent for any material changes to my treatment plan.

Your first naturopathic appointment will generally last 60 (pediatric) –90 (adult) minutes and may include a physical examination and referral for laboratory testing. Follow-up appointments may range from 15–60 minutes, depending on individual health requirements. The initial consultation fee is \$170 pediatric–\$250 adult and does not include the cost of laboratory testing, supplements, prescription items, or other recommended products or services. Follow-up consultation fees are prorated at \$150 per hour. Naturopathic services are not covered by OHIP; however, many extended health-care insurance plans provide coverage. It is my responsibility to confirm coverage with my insurance provider. Fees are subject to change with notice. I acknowledge that I have been informed of and understand the fees associated with naturopathic care.

I understand that participation in naturopathic care is voluntary and that alternatives are available. These may include, but are not limited to:

- Consulting a medical doctor, specialist, or other regulated health-care professional
- Seeking care from another naturopathic doctor
- Pursuing conventional medical treatments, including pharmaceutical or surgical interventions
- Choosing not to pursue treatment at this time

I understand that I may discuss these alternatives with my naturopathic doctor and ask questions before deciding whether to proceed. I understand that choosing not to proceed with recommended naturopathic assessment or treatment may result in:

- Persistence or worsening of symptoms
- Delayed improvement or recovery
- Progression of an underlying condition
- Reduced opportunity for prevention, early intervention, or symptom management

I understand that Dr. Musclow, ND is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% cancellation fee if providing less than 48 hours notice for cancelling appointments** \_\_\_\_\_ (please initial). I acknowledge that I have been informed of and understand the fees associated with naturopathic care.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FOR COLLECTION, USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern. The personal health information you disclose to Dr. Sandy Musclow, ND, MAC, MSc during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history. Dr. Musclow, ND and administrative staff of Foundation Stone Medicine will collect, use and disclose information about you for the following purposes:



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- TO ASSESS YOUR HEALTH CONCERNS; TO PROVIDE HEALTH CARE AND ADVISE YOU OF TREATMENT OPTIONS; TO COMMUNICATE WITH OTHER HEALTH PROVIDERS; TO ESTABLISH AND MAINTAIN CONTACT WITH YOU; TO INVOICE FOR GOODS AND SERVICES, PROCESS CREDIT CARD PAYMENTS; AND AS REQUIRED BY LAW.

Administrative staff of Foundation Stone Medicine will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose your personal health information so as to protect your privacy and the confidentiality of your information. I have reviewed the above information and authorize Dr. Sandy Musclow, ND, MAc, MSc and administrative staff of Foundation Stone Medicine to collect, use and disclose my personal health information as outlined above.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_



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